Far Southwest Region Partnership Strategic Planning Report

Southwest Virginia Behavioral Health Board, August 1st, 2004

Regional Partnership Planning in the Far SW region of HPR III is the primary responsibility of the Southwest Virginia Behavioral Health Board. Chartered in 1992, the SWVBHB consists of the Executive Directors of the region's six CSBs, the Facility Directors of the Mental Health Institute and the Mental Retardation Training Center serving the region along with family and consumer representatives. Working on their mission to enhance the availability and quality of services and supports to consumers with mental retardation, mental illness and substance abuse issues in the 17 counties served by the six CSBs and the two state facilities, the Board has re-adopted Guiding Principles of Behavioral Health Services Delivery (in 2003); a copy is attached to this report. The Board and its constituent entities strive to provide community and facility based services that are of the highest quality and delivered in a timely manner to meet the consumers needs. The Board has a long history of partnering with consumers and families to participate in treatment decisions that meet their expectations and provide the greatest extent of choice available. The Board has embraced the concepts of self-determination and empowerment for all consumers.
Covering an area of nearly 6,000 square miles and providing service to 540,000 consumers, the region has only a handful of what could be considered urban areas along with large areas of sparsely populated rural tracts of land. The Board's strategic direction has been focused on maximizing existing resources through innovative program development while advocating for additional resources to meet the unique needs and character of Appalachian communities. For reinvestment to succeed some primary investment is needed within the region. An expanded framework of community based care infrastructure and acute inpatient treatment options is required. The Board continues to support regional efforts of quality improvement and programmatic efficiency, but also is committed to securing additional resources that are reflective of the region's mission that all behavioral health services shall promote recovery, community integration and instill hope for the future.

Regional Partnership Plan Overview:

1. Broad consumer, family and stakeholder input. Through a series of Partnership Planning Conferences in the fall of 2003 our region received significant input that is detailed further in this report.
2. MR/MI Program, PATHWAYS. Located on the campus of the SWVTC this specialized treatment program for dually diagnosed consumers addresses the difficult treatment needs of consumers whose problems require more specialized treatment than that typically available in a facility dedicated to only one treatment realm. The council of MR Program Directors, Training Center staff and CSB Clinicians exhibit the best of regional planning in their collaborative problem solving that focuses on the needs of the consumer as well as program development. Recently approved Medicaid

reimbursement for this program has allowed the development of this added service.

3. Transitions to Reinvestment Workgroup (TRW). This Board workgroup has focused on development of a UM program for adult admissions at the Institute and identifying community-based program improvement opportunities. Extensive review of data from Institute admissions and the CSBs has provided material support for the belief that sub-acute community interventions and acute inpatient treatment options are limited by many factors, resulting in high numbers of Institute admissions. These factors are noted in the attached SWOT analysis.
4. Emergency Services Workgroup. Regional representation of ES Directors / Supervisory staff and Institute staff are coordinating on issue identification and problem solving for acute admission referral and crisis intervention services.
5. Inpatient Purchase Of Service (POS) Project. A pilot for bed purchase utilizing one-time state funding has been developed and implemented. This pilot includes two of the region's four private psychiatric facilities. Despite the limited funds for this pilot it will kick start the process of developing a regional POS project and Utilization Management. A second phase for bed purchase is being developed that will involve all the private psychiatric facilities in the region. UM data supports the experiential observation that indigent consumers could be treated closer to their residence with bed purchase dollars. However, the impact of any bed diversions will be dependent on the amount of resources for bed purchase and whether sub-acute community based interventions are funded as well.

SWOT Analysis of the Region:

The following pages are a regional SWOT analysis of internal strengths and weaknesses and external opportunities and threats as identified by our Board and the TRW:

SWOT Analysis for Far Southwest Regional Partnership

Strengths	Weaknesses	Opportunities	Threats
• The Southwest VA Behavioral Health Board and communication among individual CSBs, Training Center and the Institute. • A well developed and integrated network of Consumer and Family Advocacy groups that are very involved regionally. • CSB services are high quality and staff is invested in creative use of resources in the face of decreasing state funding. • Very experienced cadre of CSB and Facility managers, with strong leadership skills. • CSB and Facility staff that are dedicated to their mission of meeting the needs of consumers with commitment and compassion. • Two private psychiatric units are managed by local CSBs, increasing management influence of admission practices and allowing for ease of initiation of pilot bed purchase project. • Consumers and families positively perceive facility and community based services. • Region's culture has strong family ties and faith based supports. • Stable staffing at public and private hospitals have allowed relationships to be built and grow over time. These positive relationships result in cooperative approaches to continuum of care issues. • Discharge Planning is a high priority and creative plans are developed to meet consumer's needs. • MR/MI program, Pathways, is a regional project with strong MR teams from the individual CSBs. • Vocational services encourage empowerment and self-determination of consumers through employment. • Public facilities and CSBs provide care in a cost effective manner. • SWVMHI has cultivated expertise in Psychiatric Rehabilitation modalities. • Public Facilities and CSBs continue to innovate to better meet regional needs.	• 120 years of Institutional focus in the region. Dependency on Institute to accept all referred admissions. Consumers and families perceive more value with "one stop" full care that is provided at SWVMHI. • Case loads of staff exceed acceptable staff to client ratio. There is greater demand for service than capacity across all elements and systems. • Region continues to tolerate that we can do more with less; tendency to focus on meeting needs of the consumer rather than system changes. • High level of poverty and dependency on the public system. Poor economic conditions increase feelings of depressions and helplessness in the workforce. • Large geographic area and inadequate public transportation. • Funding for housing is almost non-existent. • Limited Psychiatry hours at community services. • Consumers not meeting mandated priority population requirements are underserved, such as those with SA issues. • Staff recruitment difficult when large area of region is a MH professional underserved region. Recruitment and retention of qualified staff is complicated by low levels of CSB salaries. • MR consumers have had limited discharge opportunities d/t lack of waiver slots. • Lack of medical resources for under-insured and indigent consumers results in more medically fragile MH/MR/SA consumers. Free clinics cannot handle the demand for services. • Lack of funding for medical evaluation of indigent consumers may create reluctance by private facilities to accept referrals. • Limited Forensic based interventions; Drug courts and limited resources for NGRI consumers. • Shift from rehabilitation model to disability-funded model has created a disincentive for supported employment for SMI consumers. • Need for staff training & skill development for consumers with co-occuring disorders. • High quality discharge planning has been level funded in the face of increasing demand. • Lack of social opportunities for consumers increases feelings of isolation.	• Needs are so great and resources are so sparse that a strong case can be made in competition with other regions for state funds. • Health Professional Shortage Areas (HPSA) in all CSBs, other than Highlands. • Development of three new regional jails provide opportunity to get in on planning in-jail services. • No prior history of state allocation for bed purchase should place us at top of "most need" list. • Possible investment of funds for community medical care purchase for indigent private acute psychiatric admissions. • Expansion of coordinated services with private facilities. • Work closely with medical schools training programs for recruitment. Creative partnering with education providers can extend programming as well as provide sources of potential staff. • Work with Adult Living Facilities for specialized services. • Partner in statewide Reinvestment. • New MR waiver slots that have been approved for state and region. • Develop specialized ALF for high needs consumers. • Technology applications can enhance the work and foster efficient use of resources. • Keystone Residential Services for adolescents in region. • Access to long-acting injectable risperidone through aftercare pharmacy. • Expanding Vocational and IDC services gives opportunities for employment to our consumers. • Utilize investment funds to shore up existing community-based infrastructure and create additional service modalities that will reduce demand for in-patient services. • Regional jails with additional capacity and built in mental healthcare provisions will lessen demand for forensic admissions. • Continued efforts to increase cultural awareness and education of MH/MR/SA issues to lower negative perceptions of our consumers and treatment. The Emory & Henry MH Walk is a fine example.	• Reinvestment, as opposed to investment, is seen as a threat to the stability of the public MH system. • Large sections of the general public does not place value on public MH system, other than as a means to control deviancy. • Overwhelming service needs for shrinking community services dilutes the effectiveness of early intervention and results in high census at SWVMHI. • Lack of indigent medical care funding is deterrent to private sector accepting indigent admissions. • Limited funding for persons w/o Medicaid and public dollars continue to shrink. • Limited funding and low salaries available regionally for professionals. • ICF-MR regulations may limit ability of Pathways to serve dually diagnosed population. • Lack of incentives for Adult Living Facilities to work closely with psychiatric services to improve training. • Decreased resources for all Ancillary Organizations (DSS, DRS, Court Services, etc.) • Limited resources for elderly and increasing needs for this population without infrastructure to support this. • Application of VA Code &/or changes in the VA Code that ultimately are not in the best interest of our consumers. • That our planning becomes primarily driven by finances rather than patient care. • Decreased funding for Early Intervention Services. • Inadequate resources increases risk of Olmstead Violations. • SA issues are not addressed in Reinvestment funding initiatives. • Commonwealth (Nation) will not address medical needs of our consumers. • Region lacks infrastructure to support advanced communication technologies. • Lack of additional Discharge Assistance Plan funding will further reduce acute care capacity as these patients "back-up" on the acute care units. • The state's failure to address non-

SWOT Analysis for Far Southwest Regional Partnership

Strengths	Weaknesses	Opportunities	Threats
	• Budget cuts have forced leaner Facility and CSB staffing. • Tendency of private psychiatric facilities to select those patients with relatively lower levels of acuity and complexity results in SWVMHI to become "risk-saturated". • Public facilities have difficulty recruiting and retaining staff due to a variety of factors; years w/out pay raises makes salaries non-competitive, potential for patient on staff violence, nationwide shortages in some healthcare job segments and lack of mental health parity eventually leads to downward wage pressures. • Limited community resource infrastructure (i.e. intensive out-patient, day hospital, PACT for all CSBs, etc.) results in excess demand for admission. • Long-term rehabilitative needs cannot meet demand, resulting in a back up of these patients on the acute admission units. • Lack of community-based forensic evaluators means that SWVMHI staff must perform all regional out-pt. evaluations. • High rate of admits of jail transfers that must then be housed with civil admission patients. • Fluctuating average daily census of Adolescent Unit at Institute results in sub-optimal milieu. • Region lacks a back up plan for periods of excessive census at the Institute. • Large number of ALFs allowing for influx of clients from other areas where a lack of available resources impels their placement in our region. • Lack of highly trained (or educated) staff in ALFs. • Decreased awareness of need for coordination of services between CSBs and primary care, hospitals, etc. • Realtively large population of indigent clients without a Third Party Payor.	• Easing access to care will reduce pressure for acute forms of care, resulting in less restrictive and more cost-effective forms of care. • Removing barriers to state psychiatric facilities from billing Medicaid (the IMD Exclusion) will lead to enhanced revenue for facility based care. • Expand pilot for the rest of the region regarding ALF/CSB relationships in light of the large number of ALF beds.	competitive salaries will exacerbate an already tight healthcare labor market. • If Partnership Planning / Investment does not address a full array of services then consumer services will be further eroded. • Budget dynamics within area jails lead to reductions in MH services for inmates. This results in some of these inmates being admitted to SWVMHI. • Heavy pressure from oversight and payment agencies mandates staff training and paperwork requirements that create further staffing level changes. • Increased litigiousness of society decreasing the amount of effective treatment that can be accomplished safely in an outpatient environment. • Spiraling cost of medications. • Increased reliance on fees without positive changes in state resources results in a narrowing down of our patient focus. • Third party insurance payments have not kept pace with inflation. • That we measure and study issues, but are slow to implement recommendations.

Consumer, Family and Stakeholder Involvement in our Planning Process:

Our region has made significant efforts to involve community stakeholders in our planning process and goals setting. Our region held five Planning Conferences this past fall, with just under 350 participants. We had a broad level of participation that included representatives from the following groups;

- Consumers
- Family members
- CSB Staff
- State Facility staff
- Private Hospital Director/Administration, Nurses
- Private agencies (ALF's)
- Local law enforcement
- Magistrates
- Local Legislators, County Representatives
- Physicians
- Private providers (LPC's, LCSW's)
- Local school system

Reactions to the presentations of the conferences were slightly more positive than not. It was a recurring theme that this process, once begun, continues with broad consumer involvement. Stakeholders were cautious of any suggestions that services be reduced from their present level (such as closure of any state beds). The planning conferences concept of local community activism to effect changes from local CSBs, facilities and at the state level was encouraged to continue and expand. A full report of stakeholder feedback has been collated and distributed to all of the Board members, CSB and facility representatives as well as our Consumer and Family Advocacy groups.

July 2004 Community Public Forums:

There were two public forums held in the far Southwest Restructuring Planning Region to review our current strategic plan and solicit feedback from stakeholders on our restructuring and planning efforts at this time. There were a total of 105 participants at the forums. A PowerPoint presentation was utilized to explain the purpose of our forums, the nature of the SW VA Behavioral Health Board and our planning efforts and associated projects to restructure the MH care system. An opinion form was utilized to solicit feedback on Stakeholders opinions of our current planning for Restructuring, as well as gauge their support for recommendations of state level actions.

Stakeholder's opinions of our Strategic Planning Goals and State Level Recommendations are contained in Attachment B.

Emerging Trends:

Our region is a sparsely populated rural portion of the Commonwealth. Although we are justifiably proud of our accomplishments in our efforts to meet our consumer's needs in the face of shrinking resources and funding, there are economic and social challenges that do have an impact on our efforts. Using data from the VA Atlas of Community Health, some key indicators of our regions health and economic status are listed below.

FAR SW VIRGINIA ECONOMY

Locale	Estimated Uninsured (2001)	% Estimated Uninsured (2001)	% Medicaid	% Below Poverty	% Unemploy-ment	Child care slots/1,000 children = 14 years	Median Household income	% Job growth	Fiscal Stress Index
Bland	1,396	20.4	8	12.4	5.9	81.4	$30,397	0.99	164.0
Bristol City	3,538	20.4	14	16.2	4.0	286.0	$27,389	1.00	179.6
Buchanan	5,372	20.4	18	23.2	7.7	42.3	$22,213	1.02	180.6
Carroll	5,994	20.4	10	12.5	10.9	87.3	$30,597	0.95	168.7
Dickenson	3,331	20.4	19	21.3	16.9	49.0	$23,431	1.00	173.6
Floyd	2,896	20.4	8	11.7	4.5	38.9	$31,585	1.01	163.2
Galax City	1,357	20.4	19	18.6	8.3	498.9	$28,236	0.95	177.3
Giles	3,430	20.4	9	9.5	6.9	78.6	$34,927	1.01	165.8
Grayson	3,616	20.4	11	13.6	10.6	66.3	$28,676	0.95	167.7
Lee	4,780	20.4	23	23.9	5.5	80.5	$22,972	1.03	171.8
Montgomery	16,961	20.4	5	23.2	3.1	260.3	$32,330	1.01	164.5
Norton City	793	20.4	22	22.8	5.1	235.4	$22,788	1.00	176.0
Pulaski	7,145	20.4	10	13.1	10.1	99.0	$33,873	1.01	165.9
Radford City	3,132	20.4	5	31.4	4.6	364.7	$24,654	1.01	173.2
Russell	6,140	20.4	16	16.3	7.3	82.4	$26,834	0.99	169.8
Scott	4,774	20.4	14	16.8	4.9	74.7	$27,339	1.00	166.4
Smyth	6,709	20.4	11	13.3	8.8	112.1	$30,083	0.96	170.5
Tazewell	9,012	20.4	14	15.3	4.4	83.4	$27,304	1.03	167.9
Washington	10,456	20.4	9	10.9	5.9	115.9	$32,742	1.00	163.6
Wise	8,145	20.4	18	20.0	5.6	57.4	$26,149	1.00	173.0
Wythe	5,666	20.4	11	11.0	9.7	114.5	$32,235	0.98	168.5
Region **LOW**	**793**	**20.4**	**5**	**9.5**	**3.1**	**38.9**	**$22,213**	**0.95**	**163.2**
Region **MEDIAN**	**4,780**	**20.4**	**11**	**16.2**	**5.9**	**83.4**	**$28,236**	**1.00**	**168.7**
Region **HIGH**	**16,961**	**20.4**	**23**	**31.4**	**16.9**	**498.9**	**$34,927**	**1.03**	**180.6**
STATE	**1,070,972**	**14.9**	**7**	**9.6**	**3.5**	**197.7**	**$39,493**	**1.01**	**165.0**

Source: VA Atlas of Community Health, 2004

The region will be one of two pilots for the Virtual Private Network. Discharge Planners and hospital liaisons are excited by this new opportunity and it is hoped that that an encrypted network may allow enhanced access in the future for a regionally focused UR that could be potentiated by this level of secure access at multiple locations, simultaneously.

Operational Efficiency and Cost Savings:

The department had asked for recommendations or a description of opportunities to achieve operational efficiencies and cost savings. This has been discussed amongst the Board and our TRW group and there is the consensus that our region has collectively achieved a high level of operational efficiency that is partially illustrated by the following informational tables drawn from DMHMRSAS data. Note that our Restructuring Planning Region's totals are a portion of those for the Health Planning Region III (listed as "Southwestern Virginia"). This first table illustrates the local funding that our region has received. Our regional governments have the same challenges that our consumers experience and we do not have local funding sources that come anywhere close to the state per capita levels.

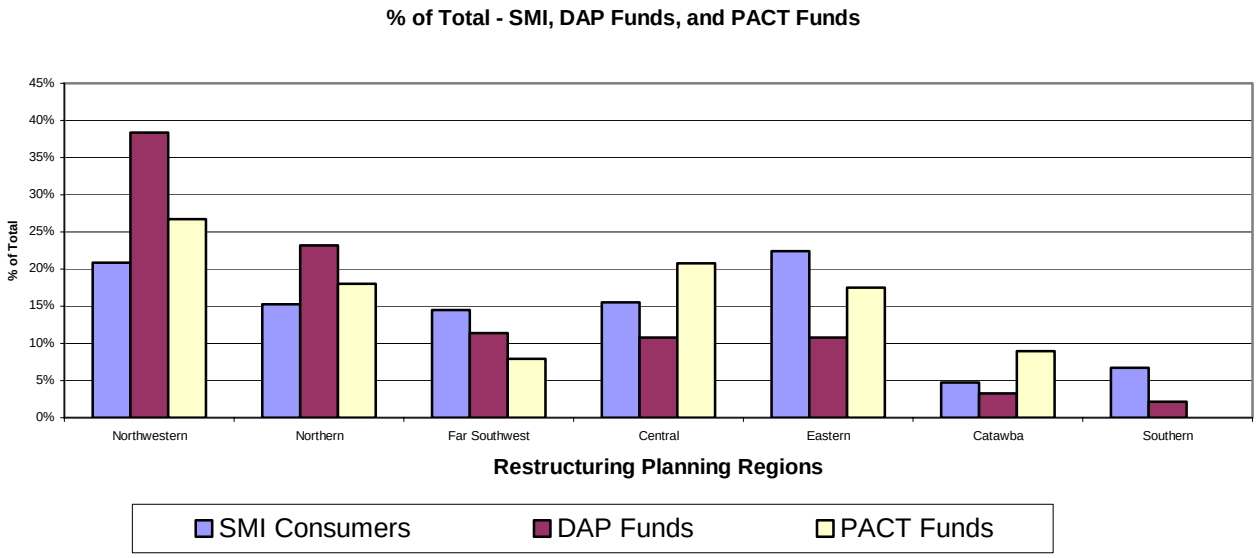
Local Funding				
Health Planning Region	**Data**	**Total**	**HPR Local Funding Per Capita**	
Northwestern Virginia	Local Funds	3,684,478	**$**	**3.61**
	Population	1,019,548		
Northern Virginia	Local Funds	109,585,395	**$**	**60.37**
	Population	1,815,197		
Southwestern Virginia	Local Funds	4,177,487	**$**	**3.19**
	Population	1,307,816		
Central Virginia	Local Funds	21,495,921	**$**	**17.64**
	Population	1,218,327		
Eastern Virginia	Local Funds	11,233,123	**$**	**6.54**
	Population	1,717,627		
Total Local Funds		**150,176,404**	**$**	**21.22**
Total Population		**7,078,515**		
Far SW Virginia Region	Funds	1,702,208	**$**	**3.02**
	Population	564,464		

When our region is compared to other HPR for total amounts of Local, State and Federal Funding, we are still less than the state average per capita amounts for all 3 funding sources. In the absence of general funds to support our programs and services, we have had to maximize those services that are billable from third party payors to offset these differences.

Total Local/ State/ Federal Funding		
	Total Direct Governmental Funding	**Direct Governmental Funding per Capita**
Northwestern Virginia	**$ 37,488,407**	
	1,019,548	**$ 36.77**
Northern Virginia	**$ 157,266,388**	
	1,815,197	**$ 86.64**
Southwestern Virginia	**$ 55,513,850**	
	1,307,816	**$ 42.45**
Central Virginia	**$ 67,015,778**	
	$ 1,218,327	**$ 55.01**
Eastern Virginia	**$ 72,229,031**	
	1,717,627	**$ 42.05**
Total Local, State, Federal Funds	**$ 389,513,454**	**$ 55.03**
Total Population	**7,078,515**	
Far SW Virginia Region	25,165,232	**$ 44.58**
	564,464	

This high level of operational efficiency for our billable services and fees collected and quality improvement efforts help to compensate for the local matching funds resource shortfalls in providing the services that our consumers need, but it is a continuing struggle to meet the demands for our services in a timely and cost effective manner. One outcome of our success in maximizing billable services that meet Medicaid and Medicare standards is the inflexibility in designing unique programs or services that do not rely on rigid payment guidelines. As we had stated in out SWOT analysis, the demand for our services exceeds our capacity to provide them at current staffing and resource levels.

The following information is from the DMHMRSAS showing the 7 restructuring planning regions and the percentage of funds they've received of the total state dollars allocated for Discharge Assistance Plans (DAP) and PACT. The blue bar represents the percentage amounts of Seriously Mentally Ill (SMI) consumers in the state served by these regions.



Source: Virginia DMHMRSAS, 2004

To put this graphic into perspective, our region accounts for slightly less than 8% of the states total population yet we have 14% of the identified SMI cases in the Commonwealth. Despite having the highest rate of SMI consumers (1153.8 SMI adults/100,000) in the state, our total DAP/PACT dollars received for each SMI adult is 70% of the state average of DAP/PACT dollars/SMI adult. This is just one more of the dynamics that impact utilization of the Institute and challenges in actualizing effective discharge planning. Case management and innovative services such as intensive mental health supports are dependent on Medicaid funding in providing services to maintain community placement for many of these consumers. The malleability of DAP and PACT funding provides individualized supports for SMI consumers that is designed by their needs and not limited by immutable payment structure guidelines such as Medicaid.

The Board proudly supports the efforts of our CSBs to provide the services they do with the numbers of underinsured consumers and overwhelming demand for interventions. But we are just as equally aware of what increases in the scope of services that we could provide with additional resources.
We respectfully submit that as a region we have achieved a high level of administrative, operational and cost/service ratio efficiency. We have studied and planned on how to increase services to our consumers and we have implemented all of those services or programmatic changes that are resource neutral. An infusion of resource funding would allow us to realize those services that are made evident by the region's needs but not eligible for funding in traditional fee for service structured billing.

The recent allocations of DAP-PACT-POS funds to be released from the Department will help to initiate or expand services for our consumers and we would like to extend our appreciation to the Department for our consideration and award of these funds.

Critical Issues Facing the Region:

- Numbers of MR consumers on Community MR Waiver Urgent waiting lists.
- Shortage of Guardians, Legally Authorized Representatives. Administrative, legal process and costs involved may be barriers for potential LARs.
- Supports for children with MR in the community.
- Qualified staff and Emergency Services for MR consumers in crisis.
- Shortage of qualified staff and educational resources/support to provide services for dually diagnosed (MR/MI) consumers.
- Economic Challenges; high rate of un-insured consumers & high unemployment rates.
- Absence of consistent transportation for consumers.
- Shortage of licensed and experienced MH/MR/SA providers.
- Few Private Acute Inpatient facilities, resulting in risk to POS project in one opts out or inadequate private bed capacity to impact SWVMHI census.
- Need for Sub-Acute crisis services as an alternative to hospitalization.
- Inadequate funding for consumer housing impacts treatment outcomes and places consumers at risk of homelessness.
- Lack of medical resources for indigent population, noting that one in five in our region are without insurance.
- Lack of coordination between service providers (Medical, Behavioral, Social Svcs.)
- Limited Forensic based interventions. Budget reductions have eliminated CSB based forensic evaluations.

Strategic Goals, Objectives and Strategies:

- Increase Community Based Services
  - Effective utilization of FY 05-06 funds for expanded services; DAP, PACT MR Waivers, etc.
  - Continue advocacy for funding to expand CSB/BHS infrastructure.
- Reduce utilization of SWVMHI
  - Initiation of Inpatient POS project is targeted to maintain more predictable Acute admissions.
  - Region's dependency on SWVMHI prohibits bed closures at this time, will focus efforts on census reduction.
  - Long range goal of bed closures within 5 years IF Inpatient POS projects are adequately funded and there are no reductions in private psychiatric beds.
- Inpatient POS projects providing Acute Psychiatric treatment will treat consumers closer to home and facilitate multi-system partnering for local psychiatric care.
- DAP plan expansions for FY 05-06 will reduce Institute utilization, expand community-based resources and promote positive outcomes for SPMI consumers identified for these services. DAP discharges from SWVMHI will free up admission beds now tied up by consumers

waiting for ERS beds. Number of consumers served will be dependent on funds available. The region is expected to receive funds for approximately 14 DAP plans.

- Formation of a 2nd PACT program in the region will effectively utilize state funds for a dynamic community based intervention that will have the goal of improving treatment outcomes, maintaining placement in community, reducing utilization of inpatient services, increasing participation in recovery/treatment plans and address co-morbid issues that complicate treatment. Goal is to serve 75 SPMI consumers in the Mt Rogers CSB catchment area.
- Secure MR Waiver Slots for those consumers on the Community Urgent Waiting lists.
- Access Facility Based MR Waiver slots for MR Consumers in SWVTC and SWVMHI.
- Increase Public Education / Awareness of Mental Health, Mental Retardation and Substance Abuse issues.
  - Public education effort from MR/MI program, "Pathways", targets both the public and increasing direct care staff awareness.
  - Partnering with consumers & family members in MH Awareness efforts such as "Consumer & Family Involvement Project".
- Continue consumer and family involvement in strategic planning and decision making for the region. The inclusion of stakeholders as voting members of the Southwest VA Behavioral Health Board's is indicative of this commitment to community involvement.

Recommendations for State Level Actions:

- Previous proposed legislation to raise the income level for Medicaid eligibility must be passed to expand coverage for uninsured consumers.
- State agencies actively pursue grant opportunities to increase health services for rural Virginians, seeking to partner with local public and private entities in accessing possible grant funding.
- Substance Abuse Services should be adequately funded to address the overwhelming numbers of dually diagnosed consumers and provide detoxification services in settings other than acute psychiatric facilities. The SA Medicaid initiative must be funded by the General Assembly for community based SA services development.
- Dental Services for our consumers is a vast unmet need and should be addressed as the public health issue that it is. Dental care should be covered by Medicaid.
- Virginia DOH & DMHMRSAS coordinate efforts to recruit board certified physicians (psychiatrists) and licensed mental health professionals for rural Virginians.
- DMHMRSAS partners with CSB/BHS and State facilities to advocate for legislative action to replicate evidence based practices such as mental health courts to increase services for consumers in the correctional system that need MH/MR/SA supports or services.

Assessment of region's readiness for and potential viability of significant restructuring of state facility and community services within the region:

Our strategic plan does not support nor endorse the closure of any beds at SWVMHI at this time, or in the near future. The region is initiating multiple interventions to reduce the utilization of the Institute and committing itself in principle and practice to this goal. We are hopeful that the region will be successful in census reduction at the Institute through diversions of acute admissions to private facilities and creation/enhancement of community interventions for SPMI consumers through DAP and PACT initiatives. The utilization of SWVMHI is impacted by many factors including the socio-economic dynamics, existing public / private health delivery systems and disproportionately high numbers of SMI consumers within our region. The Board is committed to the principle of restructuring the mental health service delivery system, but we will not reduce current service capacity until we are assured that consumers have access to community based services that are timely, cost-effective and represent a positive alternative to inpatient treatment at SWVMHI.

Toward this end, the Board would like to recognize the DMHMRSAS for their efforts to encourage community based interventions and will continue to advocate for increasing community based care infrastructures for Child/Adolescent Services, SA Interventions, Forensic/Jail Based Treatment and Sub-Acute Crisis interventions.

Principles of Behavioral Health Service Delivery

- Persons shall have the **opportunity to lead productive lives** and make significant contributions to the communities in which they live.
- Treatment and support services shall be provided in such a way as to **minimize disruptions** in community living.
- Responsive behavioral health services retain **responsibility for serving all persons** with mental illness, mental retardation, and/or substance abuse disorders regardless of severity of needs or current residential situation.
- The effective delivery of behavioral health services requires a **comprehensive, coordinated array of services with 24 hour access to necessary treatment**.
- Effective service systems for persons with behavioral health problems **prioritize and utilize resources for those most in need**.
- The most effective use of system resources is to focus on **natural supports, state-of-the-art clinical and services approaches, and new technologies** for service delivery.
- The development and provision of services shall be **guided by the needs and desires of consumers**, with consideration for families and the community.
- Persons have the **right to be actively involved in and make meaningful choices about their treatment and the services they use**; this process shall be one characterized by **respect and dignity**.
- Decisions about where, with whom, and how to live, work, and socialize are inherently personal and differ for each individual. People with mental illness, mental retardation, and/or substance abuse disorders have the **right to the same range of options available to the general public**, including selecting their residences, work options, social/recreational/educational activities, and medical care.
- Mechanisms shall be available to **ensure individuals'** rights.
- Services shall be highly **individualized and flexible**, recognizing the unique needs, desires, hopes and strengths of each person
- All services should be **relevant and responsive to the culture, ethnicity, age, gender and sexual orientation of the persons served**, and staff should be given adequate training, and demonstrate competence, in providing such relevant services.
- **Taking control over and responsibility for one's own life and behavior** is an essential factor in coping with and recovering from mental illness and other behavioral health problems.
- A person's **natural support system**, including family, significant others, peers, self-help groups, and other community groups and organizations are essential to recovery and community integration.
- **Family members have a unique, integral role**, and their needs and perspectives shall be included in the development and implementation of services.
- **Consumers and family members shall have opportunities for adequate education, training and supports** to effectively participate in system activities.
- Effective service systems **value and empower staff**, and provide supports to ensure that they have adequate training and professional and personal resources to perform their jobs competently, and with compassion, understanding and respect.
- The system of supports and services shall promote **partnerships among consumers, families and staff.**
- The development of effective service systems requires **strong leadership**. The purpose of behavioral health services cannot be accomplished without clearly defined expectations, responsibilities, authority and accountability.
- All behavioral health services shall **promote recovery and community integration and instill hope** for the future.

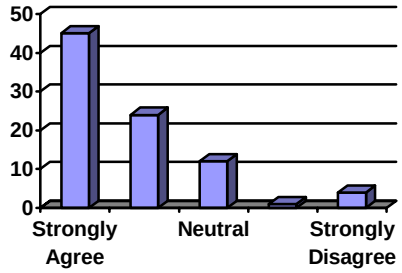
Adopted by the Southwest Virginia Behavioral Health Board for Regional Planning February 21, 2003

Far Southwest Region Partnership Strategic Planning Report

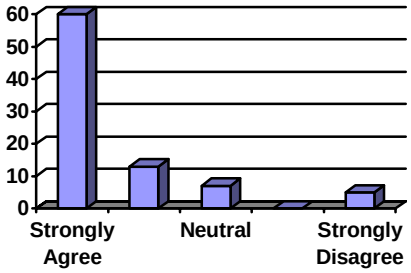
Stakeholder Responses from Far Southwest Virginia Community Public Forum.

A. Strategic Planning Goals for Far Southwest Virginia.

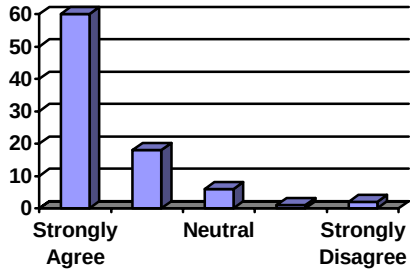
Inpatient Purchase Of Service (POS) for short-term (acute) hospitalization at participating private hospitals. Treatment closer to home. Reduction of census at Institute.



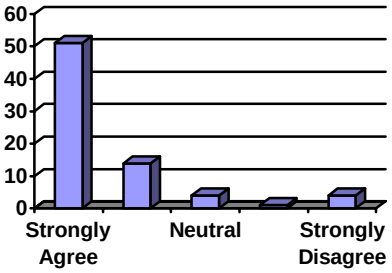
Residential and Housing Opportunities. Many consumers are interested in desirable and affordable housing alternatives to Assisted Living Facilities. Is this an important goal for you or a consumer you are involved with?



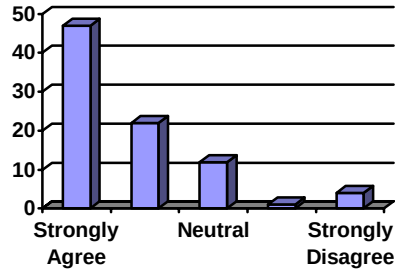
Discharge Assistance Projects (DAP) requested funds for 41 DAP plans across region. Plans aimed at innovative community based treatment so patients with complex needs can be discharged from the Institute &/or maintained in their community.



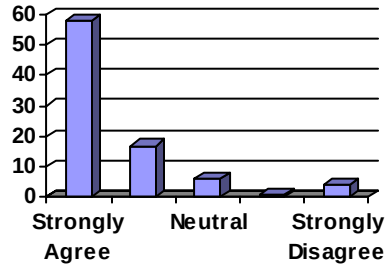
Increased availability and Access to Community Psychiatrists. CSBs have few psychiatrists available to see consumers in a timely manner or when in a crisis. Investment in CSB psychiatrist should be a high priority.



Program of Assertive Community Treatment (PACT) requested for Mt. Rogers CSB. Goal is to serve 75 consumers with Serious Mental Illness having complex needs that affect their recovery in the community.

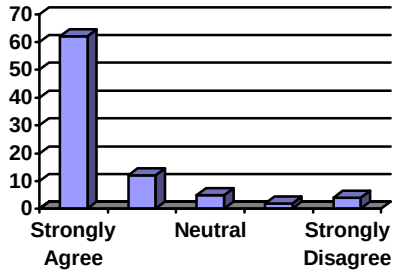


Consumer & Family Involvement in Planning. Consumers and family members should be involved on area planning boards and committees. Processes to enhance consumer and family involvement should be developed and enhanced.

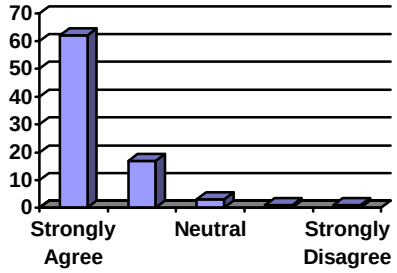


B. Recommendations for State Level Actions.

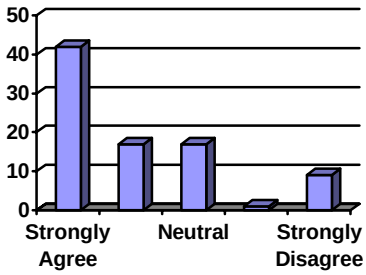
Expand Medicaid Eligibility by raising the income level limits.



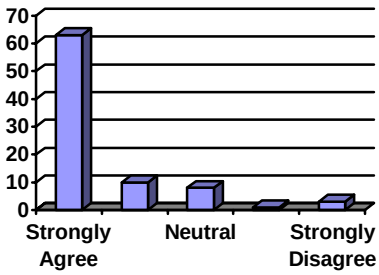
Grant Opportunities are actively pursued by State Agencies and partner with local public and private agencies to increase health services for Rural Virginians.



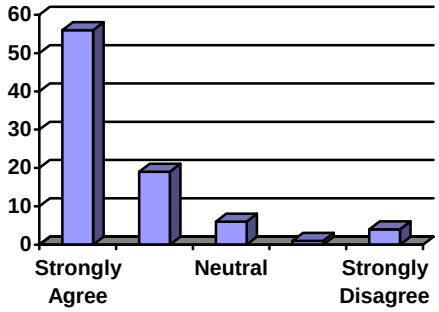
Funding for Substance Abuse Services should be increased, possibly by making this a Medicaid covered service.



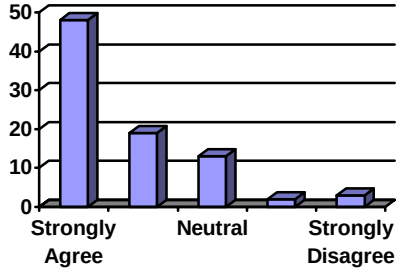
Dental Services should be made available to consumers, possibly making this a Medicaid covered service.



Recruitment of Board Certified Psychiatrists & MH Clinicians become a priority of the Virginia Department of Health & DMHMRSAS for rural Virginia.



Evidence Based Practices are not only endorsed by the DMHMRSAS but are supported with funding requests for initiation. These are clinical programs that have been proven to be effective in improving a consumer's health and wellness.



Forensic Services (Mental Health Courts, Jail Based Services) are supported by the Legislature of Virginia to provide MH/MR/SA services to those in contact with the courts & correctional system.